Honorable Ricardo S. Martinez
Trial Date: 04/24/2017

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

JENNIFER MCARTHUR,

Plaintiff,

vs.

THE ROCK WOOD FIRED PIZZA & SPIRITS,

Defendant

No. 2:14-cv-00770-RSM

DECLARATION OF CYNTHIA GOOD MOJAB

I, Cynthia Good Mojab, hereby declare as follows:

1. I am over the age of eighteen years, have personal knowledge of the matters set forth herein, and am otherwise competent to testify in court. The following information is true and accurate.

2. It is my opinion that Ms. McArthur experienced engorgement, pain, a three-day episode of heat, redness, and swelling, shooting pain, and a dime-sized, hard lump in one of her breasts, and repeated stress-induced impairment of the release of the hormone oxytocin resulting in repeatedly impaired milk ejection during pumping breaks.

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3. I am trained to recognize that the lack of milk removal leads to milk stasis (milk remaining in the breast) which leads to engorgement and pain due to distension of the alveoli (milk-making structures) and distortion of the individual cells that secrete milk. I am also trained to recognize that unresolved milk stasis leads to involution (cessation of milk synthesis). "Milk stasis can also lead to plugged ducts and inflammatory reactions in the breast, then to infectious mastitis, and then, if not corrected, to breast abscess." (page 285 of Breastfeeding and Lactation, 5th edition; Wambach and Riordan 2016).

4. Recognizing such physical issues is one of my duties as an International Board Certified Lactation Consultant (IBCLC). More specifically, my related duties are to "perform maternal, child and feeding assessment related to lactation," such as to "provide information and strategies to prevent and resolve engorgement, blocked ducts, and mastitis," "provide anticipatory guidance to reduce potential risks to the breastfeeding mother or her child," "assess and provide strategies to initiate and continue breastfeeding when challenging situations exist/occur" (Clinical Competencies for the Practice of International Board Certified Lactation Consultants, IBLCE 2012). Therefore, it is within my scope of practice and clinical competencies to recognize aspects of lactation management (e.g., insufficient frequency and duration of pumping, stress during pumping) that promote poor breastfeeding outcomes (e.g., milk stasis, engorgement, impaired milk ejection).

5. I have experience assessing symptoms of engorgement, blocked ducts, and mastitis; factors that can result in milk stasis (e.g., insufficient frequency and duration of pumping); and factors that can inhibit the release of milk (e.g., stress, pain).

6. For nearly two decades, I have facilitated support groups for lactating families in which I presented information to attendees on symptoms of, self-care options for, and breastfeeding management strategies to improve engorgement, breast pain, and symptoms of

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plugged ducts and mastitis; the risks and impact of insufficient emptying of the lactating breast on milk supply, breast comfort, and breast health; and factors that can inhibit the release of milk (e.g. stress, pain).

7. The methods I used to form my opinion have proven low error rates, are based on peer-reviewed research on the physiology and biochemistry of lactation, and/or are based on the clinical experience of experts in the field of lactation. Specifically, the physiology of milk stasis, engorgement, and involution; the symptoms and risk factors for mastitis; and factors that may block the neurochemical pathways required for milk ejection are reviewed in professional lactation texts such as Breastfeeding and Human Lactation, 5th edition (Wambach and Riordan 2016) which is co-authored by doctoral-level experts in the field of lactation with contributions by physicians and additional doctoral-level experts in the field of lactation, nursing, and pharmacology. The information in this text is evidence-based, when research is available in peer-reviewed journals, and based on professional clinical experience, when research has not yet been conducted on an issue.

8. The methods I used to form my opinion are based on information published in peer reviewed lactation-specific professional journals such as the Journal of Human Lactation, Clinical Lactation, and the International Breastfeeding Journal, as well as peer-reviewed professional medical and nursing journals, such as the Journal of the American Medical Association and the BMC Family Practice journal, publish lactation-specific articles on breastfeeding and human lactation (e.g., physiology and pathology of the lactating breast, clinical breastfeeding management, medical treatment of breastfeeding problems). In addition, professional organizations, such as the Academy of Breastfeeding Medicine, use peer-reviewed research to develop clinical protocols. A few evidence-based resources available in full online that are related to my opinion on the physical harms suffered by Ms. McArthur are:

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- Amir, L. and the Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #4: Mastitis. Revised March 2014. *Breastfeeding Medicine* 2014; 9(5): 239-243. Full text: http://www.bfmed.org/Media/Files/Protocols/2014_Updated_Mastitis6.30.14.pdf
- Cullinane, M., Amir, L., Donath, S. et al. Determinants of mastitis in women in the CASTLE study: a cohort study. *BMC Family Practice* (2015) 16:181. Full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681172/pdf/12875_2015_Article_396.pdf
- Dewey, K. Maternal and Fetal Stress Are Associated with Impaired Lactogenesis in Humans. *The Journal of Nutrition* (2001) 131:3012S–3015S. Full text: http://jn.nutrition.org/content/131/11/3012S.long

9. I obtained sufficient information to rule out other causes on a more probable than not basis because my questions included inquiring about the frequency and duration of pumping breaks, the physical amenities and degree of privacy afforded by the pumping location, the amount of milk expressed, her emotional experience of pumping accommodations, and the physical symptoms she experienced both at the Rock and at her other workplace, as well as her lactation experience outside of either workplace. Ms. McArthur identified no other potential causes of her symptoms.

10. It is my opinion that there is an increased risk that she will suffer breast cancer or ovarian cancer, abuse and neglect her children, or experience type 2 diabetes or rheumatoid arthritis.

11. I am trained to recognize that the American Academy of Pediatrics (AAP) recommends “exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.” (AAP. Policy Statement on Breastfeeding and the Use of Human Milk. Pediatrics (2012) 129(3): e827). The AAP states no upper age limit on the

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duration of breastfeeding and the consumption of expressed milk. The AAP's recommendations are based on a large body of research on the health outcomes of infant feeding (e.g., breastfeeding/human milk feeding versus formula feeding) for mothers and their infants. This non-controversial research is widely accepted in the field of lactation.

12. One of my IBCLC duties is to "critique, evaluate and incorporate evidence-informed findings into practice," "provide evidence-informed education," "provide evidence-informed information to assist the mother to make informed decisions regarding breastfeeding," "provide anticipatory guidance to reduce potential risks to the breastfeeding mother or her child," "provide appropriate education for the mother and her family regarding the importance of exclusive breastfeeding to the health of the mother and child and the risk of using breastmilk substitutes (formula)," "assist families with decisions regarding feeding their children by providing evidence-informed information that is free of any conflicts of interest;" (Clinical Competencies for the Practice of International Board Certified Lactation Consultants, IBLCE 2012) and "integrate knowledge and evidence when providing care for breastfeeding families" and "providing holistic, evidence-based breastfeeding support and care" (Scope of Practice for International Board Certified Lactation Consultant Certificants, IBLCE 2012). Therefore, it is within my scope of practice and clinical competencies to recognize and educate others on the risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

13. I have experience assessing risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

14. For nearly two decades, I have facilitated support groups for lactating families in which I presented information to attendees on risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management. Some of my

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presentations also include brief reviews of the literature on the risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

15. The methods I used to form my opinion have proven low error rates. The risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management are summarized in professional lactation texts such as Breastfeeding and Human Lactation, 5th edition (Wambach and Riordan 2016) and in the AAP's Policy Statement on Breastfeeding and the Use of Human Milk (Pediatrics (2012) 129(3): e827). The risk information in these texts is based on evidence published in peer-reviewed journals.

16. The methods I used to form my opinion are peer reviewed lactation-specific professional journals such as the *Journal of Human Lactation, Clinical Lactation*, and the *International Breastfeeding Journal*, as well as peer-reviewed professional medical and nursing journals, such as the *Journal of the American Medical Association* and the *BMC Family Practice* journal, publish lactation-specific articles on breastfeeding and human lactation (e.g., the risks of deviation from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management). In addition, professional organizations, such as the American Academy of Pediatrics, use peer-reviewed research to develop policy statements. Resources that present reviews of research related to my opinion on potential physical harms include:

- Wambach, K. and Riordan, J. *Breastfeeding and Human Lactation*, 5th edition. Jones & Bartlett 2016.
- AAP. Policy Statement on Breastfeeding and the Use of Human Milk. *Pediatrics* (2012) 129(3).

17. I obtained sufficient information to rule out other causes on a more probable than not basis because my questions included inquiring about the frequency and duration of pumping breaks, the physical amenities and degree of privacy afforded by the pumping location, the

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amount of milk expressed, her emotional experience of pumping accommodations, and the physical symptoms she experienced both at the Rock and at her other workplace, as well as her lactation experience outside of either workplace. Ms. McArthur identified no other potential causes than insufficient frequency and duration of pumping at the Rock for deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management, that lead to increased maternal health risks.

18. It is my opinion that there is an increased risk of childhood leukemia or lymphoma, allergies and celiac disease, and Sudden Infant Death Syndrome.

19. I am trained to recognize that the American Academy of Pediatric recommends "exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant." (AAP. Policy Statement on Breastfeeding and the Use of Human Milk. Pediatrics (2012) 129(3): e827). The AAP states no upper age limit on the duration of breastfeeding and the consumption of expressed milk. The AAP's recommendations are based on a large body of research on the health outcomes of infant feeding (e.g., breastfeeding/human milk feeding versus formula feeding) for mothers and their infants. This non-controversial research is widely accepted in the field of lactation.

20. One of my IBCLC duties is to "critique, evaluate and incorporate evidence-informed findings into practice," "provide evidence-informed education," "provide evidence-informed information to assist the mother to make informed decisions regarding breastfeeding," "provide anticipatory guidance to reduce potential risks to the breastfeeding mother or her child," "provide appropriate education for the mother and her family regarding the importance of exclusive breastfeeding to the health of the mother and child and the risk of using breastmilk substitutes (formula)," "assist families with decisions regarding feeding their children by

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providing evidence-informed information that is free of any conflicts of interest;" (Clinical Competencies for the Practice of International Board Certified Lactation Consultants, IBLCE 2012) and "integrate knowledge and evidence when providing care for breastfeeding families" and "providing holistic, evidence-based breastfeeding support and care" (Scope of Practice for International Board Certified Lactation Consultant Certificants, IBLCE 2012). Therefore, it is within my scope of practice and clinical competencies to recognize and educate others on the risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

21. I have experience assessing risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

22. For nearly two decades, I have facilitated support groups for lactating families in which I presented information to attendees on the risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management. Some of my presentations also include brief reviews of the literature on the risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management.

23. The methods I used to form my opinion have proven low error rates. The risks of deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management are summarized in professional lactation texts such as Breastfeeding and Human Lactation, 5th edition (Wambach and Riordan 2016) and in the AAP's Policy Statement on Breastfeeding and the Use of Human Milk (Pediatrics (2012) 129(3): e827). The risk information in these texts is based on evidence published in peer-reviewed journals.

24. The methods I used to form my opinion are peer reviewed in lactation-specific professional journals such as the *Journal of Human Lactation, Clinical Lactation*, and the *International Breastfeeding Journal*, as well as peer-reviewed professional medical and nursing

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journals, such as the *Journal of the American Medical Association* and the *BMC Family Practice* journal, publish lactation-specific articles on breastfeeding and human lactation (e.g., the risks of deviation from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management). In addition, professional organizations, such as the American Academy of Pediatrics, use peer-reviewed research to develop policy statements. Resources that present reviews of research related to 1.3 include:

- Wambach, K. and Riordan, J. *Breastfeeding and Human Lactation*, 5th edition. Jones & Bartlett 2016.
- AAP. Policy Statement on Breastfeeding and the Use of Human Milk. *Pediatrics* (2012) 129(3).

25. I obtained sufficient information to rule out other causes on a more probable than not basis because my questions included inquiring about the frequency and duration of pumping breaks, the physical amenities and degree of privacy afforded by the pumping location, the amount of milk expressed, her emotional experience of pumping accommodations, and the physical symptoms she experienced both at the Rock and at her other workplace, as well as her lactation experience outside of either workplace. McArthur identified no other potential causes than insufficient frequency and duration of pumping at the Rock for deviations from evidence-based public health recommendations on breastfeeding exclusivity, duration, and management, that lead to increased infant health risks.

26. It is my opinion that Ms. McArthur has/had an unspecified depressive disorder, unspecified anxiety disorder, unspecified insomnia disorder, and Post-Traumatic Stress Disorder ("PTSD").

27. I am trained to recognize the subjective nature of trauma and the variety of traumatic experiences that may precipitate trauma in childbearing women. I have used the

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Diagnostic and Statistical Manual of Mental Disorders, 5th edition ("DSM-5") to recognize such trauma. "The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. The DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions." (American Psychiatric Association: https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions)

The DSM-5 is also the diagnostic standard used by mental health care providers, including Licensed Mental Health Counselor Associates (LMHCAs) in the state of Washington.

Because "it is not possible to capture the full range of psychopathology in the categorical diagnostic categories" of the DSM-5, "it is also necessary to include 'other specified/unspecified' disorder options for presentations that do not fit exactly into the diagnostic boundaries of disorders in each chapter." The DSM-5 presents the symptoms and diagnostic criteria for unspecified depressive disorder (page 184), unspecified anxiety disorder (page 233), unspecified insomnia disorder (pages 420-421), and PTSD (pages 271-280).

Notably, in its criteria for PTSD, the DSM-5 does not limit directly experienced traumatic events to the kinds of traumatic events most publicized in the media (e.g., exposure to war as a combatant or a civilian). Rather, it explicitly includes threatened or actual physical assault, threatened or actual sexual violence, and torture, among other kinds of traumatic events. Furthermore, a growing body of research now demonstrates that perinatal events can be

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experienced as traumatic and lead to traumatic stress symptoms, acute stress disorder, and PTSD (e.g., childbirth, pregnancy loss) (Ayers, et al. The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychol Med* (2016) 46(6):1121-34; Bhat, A. & Byatt, N. *Infertility and Perinatal Loss: When the Bough Breaks*; full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4334933/pdf/JP2015-646345.pdf).

28. At the time of my interviews with Ms. McArthur, one of my LMHCA duties was to apply "principles of human development, learning theory, psychotherapy, group dynamics, and etiology of mental illness and dysfunctional behavior to individuals, couples, families, groups, and organizations, for the purpose of treatment of mental disorders and promoting optimal mental health and functionality. Mental health counseling also includes, but is not limited to, the assessment, diagnosis, and treatment of mental and emotional disorders, as well as the application of a wellness model of mental health." (Washington State Legislature RCW 18.225.010: http://app.leg.wa.gov/RCW/default.aspx?cite=18.225.010) Therefore, it was within my scope of practice to recognize symptoms and to diagnose unspecified depressive disorder, unspecified anxiety disorder, unspecified insomnia disorder, and PTSD.

29. I have experience assessing depressive disorders, anxiety disorders, insomnia disorders, and PTSD.

30. I have researched, written, and presented on depressive disorders, anxiety disorders, and PTSD in the context of perinatal mental health.

31. The methods I used to form my opinion have error rates deemed in the field of mental health to be sufficiently low for diagnosing psychological disorders. Specifically, the development of diagnostic criteria that comprise the DSM-5 includes the use of field trials to empirically demonstrate reliability across raters in large, diverse medical-academic settings and routine clinical practices; public and professional review; and expert review (DSM-5, pages 7-

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10). The diagnostic criteria of the DSM-5 current classification are predominantly based upon symptoms observable to and describable by the client and/or others, including the clinician. Structured and unstructured interview techniques are used to gather information from and about the client so as to ascertain which symptoms are or have been present, the severity and duration of those symptoms, and whether diagnostic criteria for any disorders are met. Additional methods include:

- The Edinburgh Postnatal Depression Scale is a 10-item, evidence-based tool developed to screen for postpartum depression in new mothers (Cox, J., Holden, J., Henshaw, C. Perinatal Mental Health: The Edinburgh Postnatal Depression Scale (EPDS) Manual. London: RCPsych Publications 2014). It yields a single score which indicates the possibility of postpartum depression.
- The Generalized Anxiety Disorder (GAD-7) 7-item Scale is an evidence-based tool developed to screen for generalized anxiety, as well as for panic disorder, social anxiety disorder, and post-traumatic stress disorder. It has also been validated for use during pregnancy and postpartum. It yields a single score which indicates the possibility of an anxiety disorder. (Kroenke, et al. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. Gen Hosp Psychiatry (2010) 32(4):345-59).
- The Perceived Stress Scale (PSS) is designed to assess an individual's perceived nonspecific stress in a given situation or a daily life situation. "Since the development of the Perceived Stress Scale (PSS, Cohen, Kamarack & Mermelstein, 1983) it has been widely used in various research such as the degree of global stress of a given situation (Leon et al., 2007; McAlonan et al., 2007), or effectiveness of an intervention on psychological stress (Holzel et al., 2010; Seskevich & Pieper, 2007; Taylor-Piliae et al., 2006), or the associations of perceived stress and psychiatric/physical disorder (Culhane et al., 2001; Garg et al., 2001). In addition,

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many studies used PSS to examine its relationship with quality of life (Golden-Kreutz et al., 2004; Golden-Kreutz et al., 2005), job satisfaction (Norvell et al., 1993), immune functioning (Burns et al., 2002; Maes & Van Bockstaele, 1999), depression (Carpenter et al., 2004), and sleep quality (Cohen & Williams, 1988). Therefore, it can be said PSS is a very important tool in assessing stress." (Psychometric properties of the Perceived Stress Scale (PSS): measurement invariance between athletes and nonathletes and construct validity; Chiu et al. 2016; Full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5162397/pdf/peerj-04-2790.pdf.)

- The Subjective Units of Distress Scale (also known as the Subjective Units of Disturbance Scale or the Subjective Units of Discomfort Scale) is widely used in research and clinical settings to allow subjective description and comparison of negative emotional states (e.g., anxiety, upset) across stimulus, setting, and time. It has been shown to be a valid tool to assess the global measures of both physical and emotional discomfort (Tanner, B. Validity of Global Physical and Emotional SUDS, Appl Psychophysiol Biofeedback (2012) 37:31–34).

32. The methods I used to form my opinion are based on articles published in peer-reviewed professional journals such as the American Journal of Psychiatry, the Annual Review of Clinical Psychology, JAMA Psychiatry, and the Journal for Nurse Practitioners, and the JOURNAL, publish mental health-specific articles (e.g., symptoms of, risk factors for, diagnosis of, and treatment of perinatal mental health challenges). In addition, professional organizations, such as the American College of Obstetricians and Gynecologists and the American Psychiatric Association, use peer-reviewed research to develop guidelines for clinical practice. A few evidence-based resources that are related to my opinion about Ms. McArthur's psychological harms are:

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th edition. 2013.

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- Laschinger, H. and Nosko, A. Exposure to workplace bullying and post-traumatic stress disorder symptomology: the role of protective psychological resources. Journal of Nursing Management (2015) 23, 252–262.
- O'Hara, M. and McCabe. Postpartum Depression: Current Status and Future Directions. Annual Review of Clinical Psychology (2013) 9:379-407.

33. I obtained sufficient information to rule out other causes on a more probable than not basis because I used screening tools and unstructured and structured interview techniques to assess whether McArthur demonstrated a risk of and met the diagnostic criteria of depressive, anxiety, and traumatic stress disorders. These approaches included inquiring about the characteristics (e.g., duration, severity, nature) of symptoms of depression, anxiety, and traumatic stress included in the DSM-5 and comparing her report of symptoms at different time periods. I also asked her about her emotional experience of lactation just before returning to work at the Rock and her emotional experience of pumping milk in the work place. McArthur identified no other potential causes of her symptoms.

34. Attached hereto and marked as **Exhibit 1** is a true and accurate copy of the scope of practice and code for International Board Certified Lactation Consultant (IBCLC) Certificants.

35. Attached hereto and marked as **Exhibit 2** is a true and accurate copy of the International Board of Lactation Consultant Examiners (IBCLE) International Board Certified Lactation Consultant® (IBCLC®) Detailed Content Outline.

36. Attached hereto and marked as **Exhibit 3** is a true and accurate copy of the eligibility criteria for the International Board of Lactation Consultant Examiners ("IBLCE") certification exam.

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37. Attached hereto and marked as **Exhibit 4** is a true and accurate copy of the IBLCE Health Sciences Education Guide.

38. Attached hereto and marked as **Exhibit 5** is a true and accurate copy of the IBLCE Health Science Education Requirements for Non-Recognized Professionals.

39. Attached hereto and marked as **Exhibit 6** is a true and accurate copy of the IBLCE Clinical Competencies for the Practice of International Board Certified Lactation Consultants.

40. Attached hereto and marked as **Exhibit 7** is a true and accurate copy of my curriculum vitae ("CV").

41. Attached hereto and marked as **Exhibit 8** is a true and accurate copy of my deposition (pgs. 9:14-25, 10:9-12, 10:25-11:2, 19:7-25, 27:12-22, 29:13-22, 29:23-30:17, 33:1-4, 33:15-23, 34:5-35:5, 35:13-25, 39:8-19, 40:1-22, 49:8-11, 49:14-16, 50:13-51:2, 50:25-51:2).

42. The IBCLC credential is the most rigorous lactation certification in the United States. Most states do not have regulations for lactation consultants specifically. Those states that do have specific licensing or certification requirements have structured their requirements around the IBLCE certification. There are no state licensing or certification requirements in Washington.

43. The IBLCE's provision of the IBCLC credential must meet the standards of the National Commissions for Certifying Agencies (NCAA). The NCCA standards are consistent with The Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999) and are applicable to all professions and industries. Certification organizations that submit their programs for accreditation are evaluated based on the process and products and not the content; therefore, the Standards are applicable to all professions and industries. Program content validity is demonstrated with a comprehensive job analysis conducted and analyzed by experts, with data

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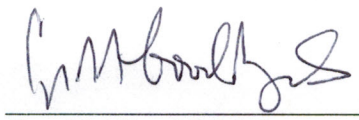
gathered from stakeholders in the occupation or industry. The NCAA accredits 80 certification programs in health care alone, including the American Academy of Nurse Practitioners Program that certifies Adult Nurse Practitioners (ANP) and Family Nurse Practitioners (FNP); the American Midwifery Certification Board that certifies Certified Nurse Midwives (CNM); the Dental Assisting National Board that certifies Certified Dental Assistants (CDA); and the National Board of Certification and Recertification for Nurse Anesthetists that certifies Certified Registered Nurse Anesthetists (CRNA).

I declare under penalty of perjury under the laws of the state of Washington that the facts I have provided on this form and any attachments are true.

DATED this 10th day of April 2017, in Lynnwood, WASHINGTON.



Cynthia Good Mojab

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DECLARATION OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on this date I caused this *DECLARATION OF CYNTHIA MOJAB* to be sent via CM/ECF to the following:

Mr. Aaron D. Bigby
NORTHCRAFT, BIGBY & BIGGS, P.C.
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Seattle, WA 98101
aaron_bibgy@northcraft.com
Attorney for Defendants

EXECUTED at Everett, Washington this April 10, 2017.

/s/ John Barton
John Barton, Attorney for Plaintiff
WSBA #25323
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